

Maryland Department of Health and Mental Hygiene  
**Encephalitis/Aseptic Meningitis Surveillance Form**

**PATIENT INFORMATION** [or MERSS ID# (if LHD completing form): \_\_\_\_\_]

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ MI: \_\_\_\_\_

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ years / months / days Sex: Male / Female

Is patient Hispanic or Latino?

RACE (Select one or more. If multiracial, select all that apply):

- ☐ 1. Yes  
☐ 2. No  
☐ 3. Unknown

- ☐ 1. American Indian or Alaska Native  
☐ 2. Asian  
☐ 3. Black or African American  
☐ 4. Native Hawaiian or other Pacific Islander  
☐ 5. White  
☐ 6. Unknown  
☐ 7. Other

Street address: \_\_\_\_\_ City: \_\_\_\_\_

County: \_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

Occupation or Setting: \_\_\_\_\_ Occupation Zip Code: \_\_\_\_\_

**CLINICAL INFORMATION**

Date of onset: \_\_\_\_/\_\_\_\_/\_\_\_\_ (required field) Current diagnosis? \_\_\_\_\_

Fever ( $\geq 38^{\circ}\text{C}$  or  $100^{\circ}\text{F}$ ) Yes / No / Unknown Altered mental status Yes / No / Unknown

Headache Yes / No / Unknown Stiff neck Yes / No / Unknown

Rash Yes / No / Unknown Joint pain Yes / No / Unknown

Seizures Yes / No / Unknown Muscle pain Yes / No / Unknown

Diffuse muscle weakness Yes / No / Unknown

Other symptoms Yes (specify: \_\_\_\_\_) / No / Unknown

Hospitalized? Yes (Hospital: \_\_\_\_\_) / No

Date of hospital admission: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of discharge: \_\_\_\_/\_\_\_\_/\_\_\_\_

Was patient transferred to another hospital? Yes (hospital: \_\_\_\_\_) / No / Unknown

Outcome: Survived / Died / Unknown Date of death: \_\_\_\_/\_\_\_\_/\_\_\_\_ Was autopsy performed? Yes / No / Unknown

**LABORATORY INFORMATION**

Was enteroviral testing requested? Yes / No / Unknown

Was arboviral testing requested? Yes / No / Unknown

Date Collected	Date Reported	Laboratory	Accession #	Test Type	Specimen	Result

**Please complete the following only if patient has preliminary positive arboviral result:**

**RISK FACTOR INFORMATION**

Has patient traveled outside the U.S. in the 2 weeks prior to onset? Yes / No / Unknown

If yes, specify when and where: \_\_\_\_\_

Has patient traveled outside Maryland in the 2 weeks prior to onset? Yes / No / Unknown

If yes, specify when and where: \_\_\_\_\_

Has patient had known mosquito bite(s) in the 2 weeks prior to onset? Yes / No / Unknown

If yes, specify when and where (geographic location): \_\_\_\_\_

Has patient spent extended time outdoors in the 2 weeks prior to onset? Yes / No / Unknown

If yes, specify when and where: \_\_\_\_\_

Has patient received transplant or blood product transfusions in the 1 month prior to onset? Yes / No / Unknown

If yes, specify: \_\_\_\_\_

Has patient donated blood products in the 2 weeks prior to onset? Yes / No / Unknown

If yes, specify: \_\_\_\_\_

Is patient pregnant? Yes / No / Unknown / Not Applicable Weeks pregnant \_\_\_\_\_ Due date \_\_\_\_\_

**VACCINE INFORMATION**

Has patient received yellow fever (YF) vaccine? Yes (Date: \_\_\_\_/\_\_\_\_/\_\_\_\_) No / Unknown

Has patient received Japanese encephalitis (JE) vaccine? Yes (Date: \_\_\_\_/\_\_\_\_/\_\_\_\_) No / Unknown

Has patient received Central European encephalitis (CEE) vaccine? Yes (Date: \_\_\_\_/\_\_\_\_/\_\_\_\_) No / Unknown

**REPORTING SOURCE**

Name: \_\_\_\_\_ Affiliation: \_\_\_\_\_

Title: ICP / Resident / Attending / Other \_\_\_\_\_ Work address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

Attending Physician (if different from above reporting source):

Name: \_\_\_\_\_ Affiliation: \_\_\_\_\_

Work Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_